BELL COUNTY VETERAN'S COURT APPLICATION

Please submit completed application to Linda Ingraham. You may submit this by fax: (254) 933-5776 , Email: linda.ingraham@bellcounty.texas.gov or in person to Indigent Defense Office. You may contact Linda Ingraham at (254) 718-2801 for further information.

Defendant's Name: _____ **Date of Birth:** _____

Address: _____ **Phone #:** _____

Email: _____ **DL#:** _____

Aliases (if any) _____ **SSN:** _____

Employment/school: _____ **Phone #:** _____

Attorney Name: _____ **Phone #:** _____

Attorney Email: _____ **Fax #:** _____

Cause Number(s)/Dates of arrest/Charge(s)

_____ / _____ / _____

_____ / _____ / _____

_____ / _____ / _____

1. **What is the defendant's county of residence?** _____
2. **Does the defendant have any other pending cases or charges: Yes** _____ **No** _____
   If yes, charges and jurisdictions: _____
3. **Does the defendant have any outstanding holds or warrants from any other jurisdiction (including immigration matters)? Yes** _____ **No** _____ **Unknown** _____
   If yes, charges and jurisdictions: _____
4. **Is the defendant currently on Community Supervision/Probation in any other jurisdiction?**
   Yes _____ **No** _____ **If yes, name jurisdiction and offense:** _____
5. **What Branch of Service did the defendant serve in?** _____
6. **What type of discharge did the defendant receive?** _____
7. **What were the dates of service?** _____ **(Please attach a copy of your DD214)**
8. **What combat zone or other similar hazardous duty area was the defendant deployed to?** _____

   _____
   Dates of deployment: _____
9. **Has the defendant been treated for/diagnosed with PTSD, a service related mental disorder or a traumatic brain injury (TBI)? Yes** _____ **No** _____ **Unknown** _____
10. **Does the attorney grant consent for the Veteran's Court Coordinator to meet with the applicant for assessment, referral(s) and explanation of program prior to being accepted into the Veteran's Court? Yes** _____ **No** _____

11. (To be completed by defendant) Please explain in your own words how you believe your experiences during your term of military service contributed to the behavior resulting in your arrest. Also, please indicate what you hope to gain from the program and what the Court can expect of you: _____

I am capable of understanding the requirements for the Veteran's Court, and the requirements have been fully explained to me by my attorney.

_____	_____	_____	_____
Defendant's signature	**Date**	**Signature of Attorney**	**Date**

For County Attorney Use Only

Reviewed by: _____ **Date** _____ **SID#:** _____

Referral _____ **Denied** _____ **Reason:** _____

OMB Number: 2900-0260
Estimated Burden: 2 minutes

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

Privacy Act and Paperwork Reduction Act Information: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 24VA10P2 "Patient Medical Record - VA" and in accordance with the Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law. The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.

TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)

VA Central Texas Health Care System
1901 Veterans Memorial Dr, Temple, TX
76504

PATIENT NAME (Last, First, Middle Initial)

SOCIAL SECURITY NUMBER

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Bell County Veterans Court
1201 Huey Road

VETERAN'S REQUEST: I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

☒ DRUG ABUSE ☒ ALCOHOLISM OR ALCOHOL ABUSE ☐ TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) ☐ SICKLE CELL ANEMIA

INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

☐ COPY OF HOSPITAL SUMMARY ☐ COPY OF OUTPATIENT TREATMENT NOTE(S) ☒ OTHER (Specify)

diagnoses,treatment plans/medications,attendance/participation in treatment,past/future appointments,lab/drug screen results,oral communication & written correspondence as needed.

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

To assist veteran with meeting legal requirements & coordination of care through the VJO program.

NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on _____ (date supplied by patient); (3) under the following condition(s):

At the veteran's request.

I understand that the VA health care practitioner's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

DATE (mm/dd/yyyy)

SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA)

FOR VA USE ONLY

IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED

RELEASED BY
Polly J. Robertson, LCSW-S

VA FORM
JUL 2013 **10-5345**

USE EXISTING STOCK OF VA FORM 10-5345, DATED MAY 2005.

OMB Number: 2900-0260
Estimated Burden: 2 minutes

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

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ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.

TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)

Killeen Heights Vet Center
302 Millers Crossing, Suite 4
Harker Heights, TX 76548

PATIENT NAME (Last, First, Middle Initial)

SOCIAL SECURITY NUMBER

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Bell County Veterans Court
1201 Huey Road

VETERAN'S REQUEST: I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

☐ DRUG ABUSE ☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) ☐ SICKLE CELL ANEMIA

INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

☐ COPY OF HOSPITAL SUMMARY ☐ COPY OF OUTPATIENT TREATMENT NOTE(S) ☐ OTHER (Specify)

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on _____ (date supplied by patient); (3) under the following condition(s):

I understand that the VA health care practitioner's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

DATE

SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA)

FOR VA USE ONLY

IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED

RELEASED BY

VA FORM MAY 2005 **10-5345**

USE EXISTING STOCK OF VA FORM 10-5345, DATED NOV 2004

OMB Number: 2900-0260
Estimated Burden: 2 minutes

Department of Veterans Affairs

INDIVIDUALS' REQUEST FOR A COPY OF THEIR OWN HEALTH INFORMATION

PRIVACY ACT AND PAPERWORK REDUCTION ACT INFORMATION

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Act. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read the instructions, gather the necessary facts and fill out the form. The purpose of this form is to provide an individual the means to make a written request for a copy of their information maintained by the Department of Veterans Affairs (VA)in accordance with 38 CFR 1.577.

The information on this form is requested under Title 38, U.S.C. 501. Your disclosure of the information requested on this form is voluntary. However, if the information including Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, VA will be unable to comply with the request. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled.

VETERAN'S LAST NAME- FIRST NAME- MIDDLE INITIAL	SOCIAL SECURITY NO.	DATE OF BIRTH

DESCRIPTION OF INFORMATION REQUESTED

Check applicable box(es) and state the extent or nature of information to be copied/printed, giving the dates or approximate dates covered by each.

FACILITY WHERE TREATED:	DATES OF TREATMENT:
Killeen Heights Vet Center 302 Millers Crossing Suite 4 Harker Heights, TX 76548	

☐ COPY OF HOSPITAL SUMMARY ☐ COPY OF OUTPATIENT TREATMENT NOTE(S) ☐ OTHER *(Specify)*

COPY OF HEALTH INFORMATION IS TO BE DELIVERED TO THE INDIVIDUAL

☐ IN-PERSON	☐ BY MAIL, TO ADDRESS BELOW *(Include City, State & ZIP)*	PHONE NO.

PATIENT SIGNATURE	DATE *(mm/dd/yyyy)*

NOTE: If signed by someone other than the patient, indicate the authority (e.g., guardianship or power of attorney) under which request is made.

VA FORM MAY 2005 **10-5345a**

Bell County Veterans Treatment Court
VA Screening/Assessment

Veteran's Name: _____

Last 4 of SSN: _____ Date of Birth: _____

Date of Assessment: _____

Clinician's Name: _____

Assessment: _____

_____

_____

If mental disorder is indicated, is it military-related? YES _____ NO _____

If PTSD is indicated, is it military-related? YES _____ NO _____

If TBI is indicated, is it military-related? YES _____ NO _____

If a Substance Use Disorder is indicated, does clinician feel it could be related to experiences in the military? YES _____ NO _____

Clinician's Treatment Recommendations

_____ STEP (or equivalent to VA's 30 day residential substance abuse treatment program at the Temple VA)

_____ SATP (or equivalent to Austin VA's outpatient substance abuse treatment groups)
Upon completion of SATP Phase 2, Veteran may be referred to aftercare or, other groups including Seeking Safety, Mindfulness, Coping Skills, etc. with referrals to PTSD and Peer Support groups as appropriate

_____ PRRP (6-8 week residential PTSD treatment program at the Waco VA)

_____ RRTP (30 day residential rehabilitation treatment program (for MH issues) at Temple VA)

_____ Individual Therapy

_____ Mental Health Groups

_____ Medications If recommended treatment, is Veteran receptive to taking medications?

YES _____ NO _____

Completed by: _____ Date: _____